Name: _____ *DOB:* _____ *Date:* _____

Current Symptoms

- ○ Anxiety or nervousness
- ○ Shortness of breath
- ○ Feeling of heart pounding in chest
- ○ Sweating
- ○ Chest pain
- ○ Easily distracted
- ○ Hearing voices or seeing things
- ○ Decreased appetite
- ○ Increased appetite
- ○ Significant recent weight loss
- ○ Significant recent weight gain
- ○ Alcohol use
- ○ Tobacco use
- ○ Thoughts of death or suicide
- ○ Depressed or sad feelings most of the day
- ○ Loss of interest or pleasure in daily activities
- ○ Fatigue or low energy
- ○ Guilty feelings
- ○ Impulsivity
- ○ Feeling paranoid (like people are out to get you)
- ○ Preoccupation about current weight
- ○ Excessive exercising/purging to reduce weight
- ○ Decreased sleep
- ○ Increased sleep
- ○ History of illicit drug use
- ○ Caffeine use

Medical History

○ Arthritis	○ Cancer	○ Diabetes	○ History of head injury	○ Seizure disorder
○ Asthma/COPD	○ Cholesterol (high)	○ Gastrointestinal	○ Heart disease	○ Stroke or TIA
○ Blood Pressure (high)	○ Chronic back pain	○ Glaucoma	○ Migraines	○ Thyroid issues

○ Other _____

Allergies: _____

Current Medications

Pharmacy: _____ **Phone**: _____